CareFirst

Retiree Benefits Enrollment & Reference Guide

HARFORD COUNTY

GOVERNMENTAL ENTITIES

Effective July 1, 2015–June 30, 2016

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The purpose of this Enrollment and Reference Guide is to provide information about your benefits options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Employee Benefit Guide or Certificate of Coverage for information about the plans.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy.

What's New for 2015–2016

Emergency Room Co-Pay

The co-pay for services in a hospital Emergency Room will change to $150.00. This will apply to both the PPO and BlueChoice Opt-Out Plus coverage.

The following changes apply to the Blue Choice Opt-Out Plus plan only:

- **Outpatient Surgery**—Coverage will now include a $50 co-pay.
- **Hospital/Inpatient**—Coverage will now include a $100 co-pay.

Benefits and Eligibility

Eligibility

Dependents*

Eligible family members include your:

- Legal spouse
- Dependent children until the end of the month in which they reach age 26
- Unmarried dependent children over the age limit if:
  - ☐ They are dependent on you for primary financial support and maintenance due to a physical or mental disability,
  - ☐ They are incapable of self-support, and
  - ☐ The disability existed before reaching age 26 or while covered under the plan.

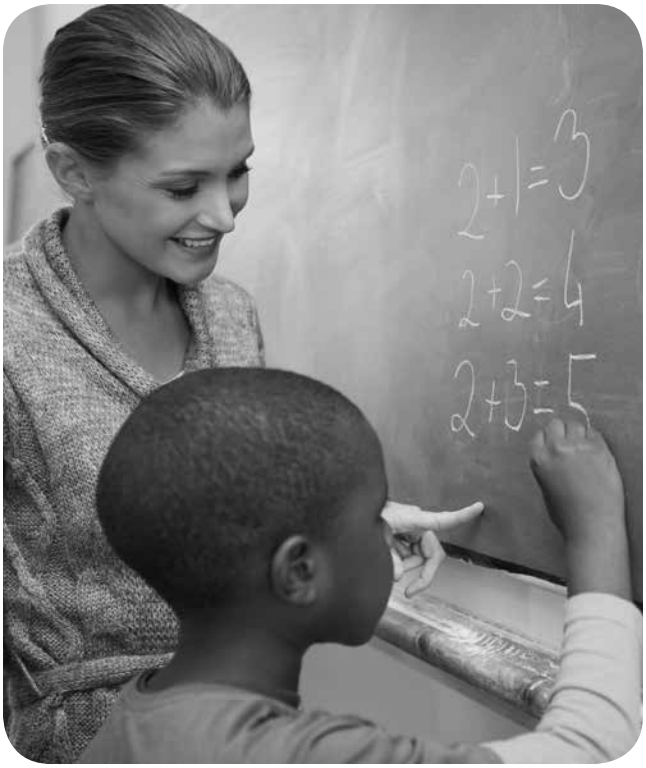
Eligible children include your:

- Natural children
- Stepchildren
- Legally adopted children
- Foster children
- A child for whom you have legal guardianship including grandchildren
- Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Live-in partners
- Children of live-in partners
- Stepchildren following divorce from natural parent
- Parents of employees



*** You must submit verification of eligibility for all dependents on your account within 30 days of enrollment.**

Dependent Eligibility Documentation Requirements

Relationship to Employee	Eligibility Definition	Documentation for Verification of Relationship
Spouse	A person to whom you are legally married	Copy of Marriage certificate that identifies employee-spouse relationship
Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	**Natural Child – Provide 1 of the following:** ■ Copy of birth certificate showing employee's name or ■ Hospital verification of birth (must include child's name, date of birth and parents' names) or ■ Certificate of birth **Step Child – Provide 1 of the above** showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren) –** Copy of Final Court Ordered Custody with presiding judge's signature and seal, or Adoption Final Decree with presiding judge's signature and seal. **Child for whom the court has issued a QMSCO** – A copy of the Qualified Medical Child Support Order
Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) **and** Federal Tax Return for year just filed. **and** Completed Disability Form (Request from Benefits Office)

Patient-Centered Medical Home

Focusing on you and your health

Whether you're trying to get healthy or stay healthy, you need the best care available. That's why the CareFirst BlueCross BlueShield[1] family of health plans has created a program to improve health care quality and help slow rising health care costs over time.

Our Patient-Centered Medical Home (PCMH) program focuses on the relationship between you and your primary care provider (PCP)—whether a physician or nurse practitioner (NP). It's designed to provide your PCP[2] with a more complete view of your health needs, as well as the care you're receiving from other providers. As the leader of your health care team, your PCP will be able to use this information to better manage and coordinate your care, a key to better health.

Treating your overall health

Whether you see your PCP for preventive care, or you need more care, your PCP is expected to:

- Coordinate your care with all your health care providers, including specialists, labs, pharmacies, and mental health facilities to help you get access to, and receive, the most appropriate care available in the most affordable settings.
- Identify and address any impact the care you receive for one health issue may have on another.
- Review all of your medications and possible drug interactions with you.
- Review your health records for duplicate tests or services already ordered or performed by another provider.

Why a PCP is important to your health

By visiting your PCP for routine visits as recommended, you can build a relationship, and your PCP will get to know you and your medical history.

A PCP is concerned with your overall health. If you have an urgent health issue, having a PCP who knows your health history often makes it easier and faster to get the care you need. Your PCP can sometimes provide advice over the phone or fit you in for a visit. That helps you avoid long lines and expensive charges at the emergency room.

When you visit your PCP for screenings and preventive services, he or she can detect health concerns in the early stages, when they are easier and less costly to treat.

1 All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

2 The doctors and other medical providers, who provide your care, are independent providers making their own medical determinations and are not employed by either CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a Care Plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse (RN), so you have the support you need, answers to your questions and information about your care.

Extra care for certain health issues

When you participate in PCMH, your PCP will take specific steps to coordinate and manage your care. If you have certain health issues, your PCP will create an online record of your health needs with specific follow-up activities.

Your care coordinator is expected to:

- Assist your PCP by coordinating your care and answering your questions.
- Follow up with you to make sure you're not having problems following your treatment plan. For example, if you have diabetes, the care coordinator can help you take steps to better understand and control your diabetes.
- Assist you in obtaining services and equipment necessary to manage your health condition.

It's your choice

PCMH is a voluntary program. When you participate:

- You pay no additional premium.
- There is no change in your benefits.
- There is no change to your health plan requirements.
- You can opt-out at any time without penalty and without changing your PCP and/or NP.

Please note that if you have a high deductible health plan, certain charges may apply until you meet your deductible.

How do I get started?

Simply sign the Election to Participate form and return it to your PCP.

You can get the form from your PCP, or you can download it from the Forms section at **www.carefirst.com/memberpcmh**. By signing the election form, you agree to give your PCP access to your health information on file with CareFirst. This includes data from claims and notes from any CareFirst programs in which you have participated.

Preferred Provider Organization

A referral-free go anywhere health plan

Designed for today's health conscious and busy families, the Preferred Provider Organization (PPO) plan offers one less thing to worry about during your busy day. Your PPO plan gives you the freedom to visit any provider you wish – any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

Benefits of PPO

- Access to our network of more than 26,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required, and no referrals to see a specialist.
- Take your health care benefits with you – across the country and around the world.
- Receive coverage for preventive health care visits at no cost.
- Avoid balance billing when you receive care from a preferred provider.
- Enjoy the freedom to visit providers outside of the PPO network and still be covered but with a higher out-of-pocket cost.

No referrals.
No PCPs.
Coverage everywhere.

How your plan works

In-network vs. out-of-network coverage

The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you are out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the PPO network (non-preferred provider), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

Hospital authorization/ Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free at (866) – PREAUTH.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your PPO coverage will become available to you.

You will have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count toward your out-of-network deductible and vice versa.

If more than one person is covered under your PPO plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your PPO plan will start to pay for services

After you satisfy your deductible, your PPO plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

In general, non-preferred providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-preferred provider, you may be balance billed based on the provider's actual charge. In addition, you may be required to pay the non-preferred provider's total charges at the time of service and submit a claim to CareFirst for reimbursement.

Depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum, CareFirst will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible and most copays and/or coinsurance will count toward your out-of-pocket maximum.

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum and vice versa.

If more than one person is covered under your PPO plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Out-of-area coverage PPO®

You have the freedom to take your health care benefits with you – across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits when receiving care from a BlueCard® preferred provider while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

BlueCard®

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home.

As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 85% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern VA), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at (800) 810-BLUE.
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

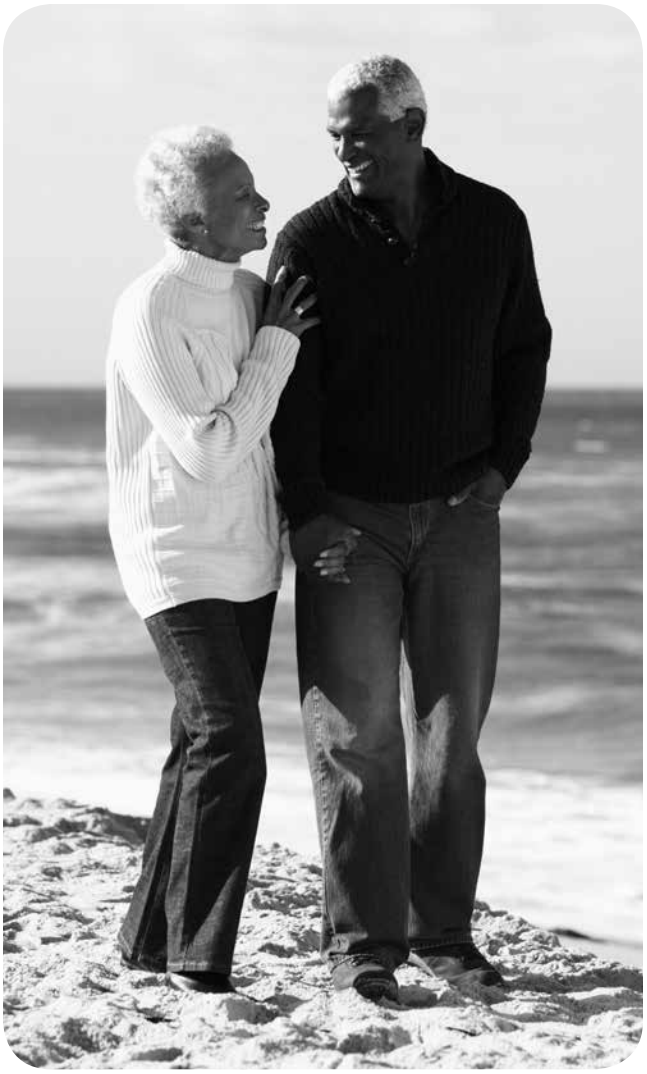
Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At BlueCard Worldwide hospitals, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At non-BlueCard Worldwide hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available online at **www.bcbs.com**.
- To find a BlueCard provider outside of the U.S. visit **www.bcbs.com**, select *"Find a Doctor or Hospital."*

Members of Maryland Small Group Reform (MSGR) groups have access to emergency coverage only outside of the U.S.

Medical assistance when outside the U.S.

Call (800) 810-BLUE toll-free or (804) 673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.



Visit **www.bcbs.com** to find providers within the U.S. and around the world.

BlueChoice Opt-Out *Plus* Open Access

A plan with predictable costs and the freedom to choose

Your BlueChoice Opt-Out *Plus Open Access* plan offers HMO advantages, like predictable copays, along with something extra: the ability to see providers outside of the CareFirst BlueChoice network. Also unique to this plan is its Open Access feature, which means you don't need to obtain a referral from your primary care provider (PCP) before seeing a specialist.

Benefits of BlueChoice Opt-Out *Plus Open Access*

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- Enjoy the freedom to visit providers outside of the BlueChoice network and still be covered but with a higher out-of-pocket cost.
- No PCP referral required to see a specialist.
- Receive coverage for preventive health care services at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider or national participating provider.
- Take your health care benefits with you when you travel.
- Enjoy your plan benefits when you're out of the area for 90 days with the Away from Home Care® program.

Visit providers outside of the network—no need to get an referral.

How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in this plan, you will select a PCP to manage your primary medical care. Make sure you select a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize

in either family practice, general practice, pediatrics or internal medicine.

This plan has an Open Access feature, which means you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

However, you may choose to call your PCP when you need care. Your PCP can:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist.

If you do not select a PCP for you and any of your covered family members, you may be charged a higher copayment (copay) for covered services.

In-network vs. Out-of-network coverage

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you visit a CareFirst BlueChoice provider. However, the choice is entirely yours. That's the advantage of this plan.

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the BlueChoice network (out-of-network), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

The Blue Cross and Blue Shield Association, made up of Blues plans across the country, has a national network of providers, called BlueCard® participating providers. If you choose to visit a BlueCard provider, you will have a lower out-of-pocket cost. Your benefits will still be paid at the out-of-network level and have balance billing protection. Find a national participating provider by visiting **www.bcbs.com.**

Hospital authorization/ Utilization management

CareFirst BlueChoice providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by out-of-network providers and out-of-area admissions. Call toll-free at (866) – PREAUTH.

BlueChoice Opt-Out *Plus Open Access* is the jointly offered Point-of-Service product with in-network HMO benefits administered by CareFirst BlueChoice, Inc. and out-of-network indemnity benefits administered by Group Hospitalization and Medical Services, Inc., doing business as, CareFirst BlueCross BlueShield (CareFirst). Each time that services are sought, you may choose to receive in-network HMO benefits or out-of-network indemnity benefits.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your full benefits will become available to you.

You will have a different deductible amount for in-network vs. out-of-network benefits. For example, when you see in-network providers, your expenses will only count toward your in-network deductible.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible, your plan will start to pay for covered services. The level of those benefits will depend on whether you see in-network or out-of-network providers.

In general, out-of-network providers do not have an agreement with CareFirst BlueChoice, Inc. to accept the allowed benefit as payment in full for their services.

Therefore, if you receive services from an out-of-network provider, you may be balance billed based on the provider's actual charge. In addition, you may be required to pay the out-of-network provider's total charges at the time of service and submit a claim to CareFirst for reimbursement. However, if you visit a BlueCard® participating provider, you will be protected from balance billing,

Depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Most amounts you pay toward your copays and/or coinsurance will count toward your out-of-pocket maximum.

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits.

If more than one person is covered under your plan, once the out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Laboratory services

To ensure you receive the maximum laboratory benefit from your plan, you must use a LabCorp® facility for any in-network laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call (888) LAB-CORP or visit **www.labcorp.com**.

Out-of-area coverage

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard®, a program from the Blue Cross and Blue Shield Association, allows you to receive out-of-network benefits when you visit a BlueCard® participating provider while living or traveling outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,000 hospitals and 1 million professional providers nationally.

In addition, members and their covered dependents planning to be out of the service area for at least 90 consecutive days may be able to take advantage of a special program, called Away From Home Care®. This program allows temporary benefits through another Blue Cross and Blue Shield plan. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away From Home Care, please call Member Services at the phone number listed on your identification card.

BlueVision

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to **www.carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **(800) 783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.[1]

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information? Please visit **www.carefirst.com** or call **(800) 783-5602.**

[1] *As of 4/1/14, some providers in Maryland may no longer provide these discounts.*

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BlueVision
A plan for healthy eyes, healthy lives

Summary of Benefits *(12-month benefit period)*

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	$10
FRAMES[1,2]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
LENS OPTIONS[2,3] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$75
Premium Progressive Lenses (Varilux®, etc.)	$125
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Lenses	$35
Scratch-Resistant Coating	$20
Standard Anti-Reflective Coating	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
CONTACT LENSES[1,2]	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
LASER VISION CORRECTION[2]	Up to 25% off allowed amount or 5% off any advertised special[4]

[1] *At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.*

[2] *CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland may no longer provide these discounts.*

[3] *Special lens designs, materials, powers and frames may require additional cost.*

[4] *Some providers have flat fees that are equivalent to these discounts.*

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

Away From Home Care®

Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, DC and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.
- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- Simply call your Host HMO primary care physician for an appointment when you need care.

Always remember to carry your ID card to access Away From Home Care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.

Rx Drug Program—3 Tiers

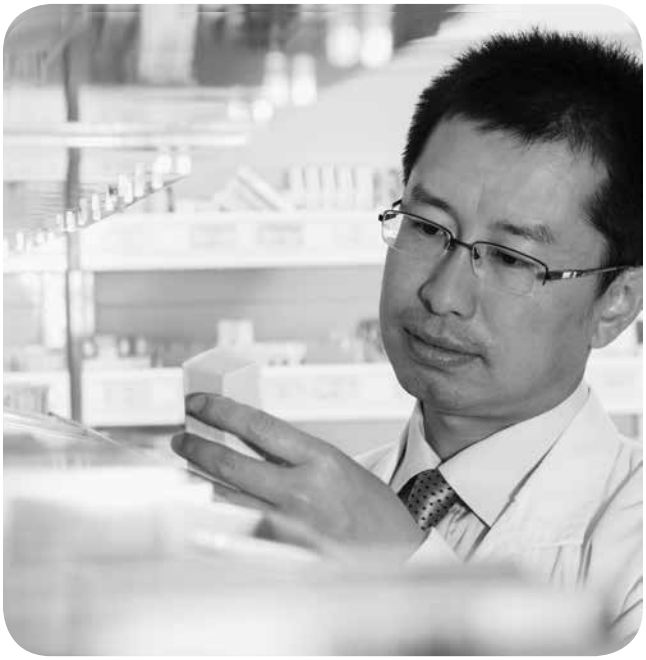
A total prescription for health

In order to receive the best possible health care, your employer is offering both medical and pharmacy benefits. By working with your doctor and pharmacist, you can focus on your overall health and make the right decisions when it comes to your prescriptions.

Your Rx benefits

Safe and cost-effective with a large network of pharmacies to choose from—that's your prescription plan. As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (collectively, CareFirst) member, you have access to:

- A network with more than 60,000 participating pharmacies located nationwide.
- Mail Service Pharmacy, our convenient, fast and accurate mail order drug program.
- Rx Specialty Support, a program designed for members who take specialty medications.
- Rx Authorize to monitor your prescription drug use.
- Educational tools and resources to help you save money, understand your plan and manage your prescriptions, at **www.carefirst.com/rx**.



Making a difference in your health

By having both your medical and prescription benefits with CareFirst, our team of health care professionals can look at total patient care to better manage your health care costs and the quality of service you receive.

Having access to pharmacy and medical claims information allows CareFirst to develop cost-effective programs in order to improve the consistency of your care. We can more accurately identify those members who could benefit from our care management programs based on early detection. It's all in an effort to provide you with the best possible care to help you maintain your overall health.

Saving money with your 3 Tier plan

The prescription drugs in your plan will fall into 1 of 3 Tiers. Tiers 1 and 2 are part of CareFirst's Preferred Drug List and have been selected for their effectiveness and price. Even though Tier 3 drugs are not part of the Preferred Drug List, they're still covered by your benefits, but at the highest copay. And remember, if the cost of your medication is less than your copay, you only pay the cost of the medication.

Once you meet your deductible (if applicable to your plan), you may pay a different copay amount for drugs depending on if you use Generic, Preferred Brand or Non-preferred Brand drugs. Should you have questions about your benefits, please call CareFirst Pharmacy Services at (800) 241-3371.

SUM1609-1P

Tier 1* You Pay: Lowest Copay ($)	Generic Drugs	All Generic drugs on the Preferred Drug List will be in Tier 1.
Tier 2* You Pay: Higher Copay ($$)	Preferred Brand Drugs	If a Generic version of a Tier 2 drug is released then: ■ The Generic drug is added to Tier 1. ■ The Brand drug moves to Tier 3 and becomes a Non-preferred Brand drug.
Tier 3** You Pay: Highest Copay ($$$)	Non-preferred Brand Drugs	Some plans require members who choose a Tier 3 drug over the Generic version to: ■ Pay the highest copay, and ■ Pay the cost difference between the Brand drug and its Generic.

** Part of CareFirst's Preferred Drug List.*
*** Self-Injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.*

Filling your prescriptions

Your Rx drug benefits can be used for both maintenance and non-maintenance prescriptions. As a CareFirst member, you can receive up to a 34-day supply of medication from a retail pharmacy or Mail Service Pharmacy. You may also request a 90-day supply of your maintenance medication and pay 2x the appropriate copay amount,[1] depending on the tier level of your medication, through your retail pharmacy or Mail Service Pharmacy.

Retail pharmacies

Simply present your prescription and member ID card at a participating pharmacy and pay a copay[1] for your medication. And with access to over 60,000 pharmacies nationwide, you can use the *Pharmacy Finder* tool located in the *Drug Tools* on **www.carefirst.com/rx** to choose a location that's convenient for you.

Mail Service Pharmacy

Mail Service Pharmacy gives you an easy way to order medications by phone, mail or online. Your prescriptions will be reviewed and filled by registered pharmacists and mailed directly to your home. Convenient, fast and accurate, Mail Service Pharmacy also allows you to:

- Consult with pharmacists over the phone, 24 hours a day.
- Check account balances and make payments using automated phone systems.
- Receive e-mail notifications about your order status.

Talk to your doctor to make sure you are using drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when using Tier 1 or Tier 2 drugs.

Maximizing your benefits

Take advantage of the free programs and resources available with your CareFirst Rx drug plan.

Comprehensive Medication Review

As part of the Medication Therapy Management program, members are eligible to participate in a free annual Comprehensive Medication Review. During the Comprehensive Medication Review participating pharmacies provide individualized, in-person consultations, medication monitoring and education; interfacing with both the member and the physician to ensure the appropriate use of medications and to reduce drug costs. To find a participating Pharmacy, click on *Medication Therapy Management* located in the *Manage Your Medications* section on **www.carefirst.com/rx.**

Generic drug education

Made with the same active ingredients as their brand-name counterparts, Generics are also equivalent in dosage, safety, strength, quality, performance and intended use.

**** Please note that you must meet your annual deductible (if applicable to your plan) before paying only a copay for any of your prescription medications.*

To begin saving money, ask your doctor or pharmacist if any of the drugs you're currently taking can be filled with a Generic alternative. You can also visit **www.carefirst.com/rx** to learn more about Generic drugs and use our Preferred Drug List to see if a Generic is available to treat your condition.

Rx Specialty support

When you need specialty medications we will provide you with personalized care to successfully manage your condition, including one-on-one therapy support, 24/7 patient assistance, refill reminders and more.

You may receive coverage for a variety of drugs used to treat the following health conditions:

- Cancer
- Crohn's Disease
- Growth Hormones Deficiencies[2]
- Hepatitis C
- Multiple Sclerosis
- Infertility Treatment Management[2]
- Rheumatoid Arthritis
- Ulcerative Colitis

[2] *Please review your policy for details on what coverage is available under your plan.*

Online tools and resources

To get the most from your Rx drug plan, you need to stay informed. At **www.carefirst.com/rx** you will find the tools and resources you need to understand your benefits, including drug recalls, cost saving opportunities and more.

- **Preferred Drug List**—Rest easy knowing that medications on our Preferred Drug List have been reviewed for quality, effectiveness, safety and cost by our Pharmacy & Therapeutics Committee and medical staff.
- **Prescription Drug Information**—Our easy-to-use, interactive tools are available 24 hours a day, 7 days a week:
  - ☐ Printable Preferred Drug List
  - ☐ Pharmacy Finder
  - ☐ Drug Pricing Tool[3]
  - ☐ Refill and Mail Order Information[3]
    Drug Reference and Interactions[3]
  - ☐ Drug Information[3]
  - ☐ Claims History Tool[3]
  - ☐ Identify a Medication

[3] *Available to members only through My Account.*

- **Rx Authorize**—Some medications are only intended to be used in limited quantities, while others require advanced approval. With Rx Authorize, you have access to a program that can help monitor your drug therapy, while promoting the use of clinically approved and cost effective prescription medications.
  - ☐ **Quantity Limits**—Look at our quantity limit list to see if your medication can only be prescribed in limited quantities.
  - ☐ **Step Therapy/Prior Authorization**—Use our prior authorization list to determine if your prescription requires advanced approval before it can be filled.
- **Maintenance Medications**—Access the most up-to-date list of maintenance medications, usually taken for 6 months or more to treat chronic conditions.

Visit **www.carefirst.com/rx** for more information and to access the most up-to-date Preferred Drug List.

health+wellness
take charge.

Whether you're looking for health and wellness tips, discounts on health-related services, or support to manage a health condition, we have the resources to help you get on the path to good health.

Online health education

Find a wide variety of health education articles, nutritious recipes and cooking videos, interactive health-related tools and more at **www.carefirst.com/livinghealthy.**

FirstHelp™

Registered nurses are available 24 hours a day to answer your health care questions. Call (800) 535-9700 with your health questions or for help choosing the best source of care.

Vitality magazine

Vitality provides updates to your health care plan and a variety of health and wellness topics, including food and nutrition, physical fitness and preventive health. All issues are available online at **www.carefirst.com/vitality.**

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more. Visit **www.carefirst.com/wellnessdiscounts.**

Health news

Get the latest information to help you and your family maintain a healthy lifestyle. To sign up for our monthly electronic member newsletter, visit **www.carefirst.com/healthnews.**

Health and wellness programs and resources help you and your family live a healthy life.

CUT7486-1P

Pedometer app

Count your steps, distance traveled and calories burned for each workout with the free CareFirst Ready, Step, Go! app. The app is available for iPhone™, iPod Touch™, or Android™ smartphones—visit your app store and search for "Ready, Step, Go!"

Coordinating your care

Whether you're trying to get healthy or stay healthy, you need the best care. CareFirst has programs to help you take an active role in your health, address any health care issues and enjoy a healthier future.

Patient-Centered Medical Home (PCMH)

PCMH was designed to provide your primary care provider with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to better manage and coordinate your care and improve your health.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a care plan based on your health needs with specific follow-up activities to help you manage your health
- Provide access to a care coordinator, who is a registered nurse, so you have the support you need, answers to your questions and information about your care

Find a participating PCMH provider in our provider directory at **www.carefirst.com/findadoc**.

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate through the health care system and provide support along the way. Our Case Managers are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call (888) 264-8648.

My Account

Online access to your claims

View personalized information on your claims and out-of-pocket costs online with *My Account.* Simply log on to **www.carefirst.com/myaccount** for real-time information about your plan.

Features of *My Account*

- View your deductible status and out-of-pocket costs for your current and previous plan year.
- Review up to one year of medical claims—total charges, benefits paid and costs for a specific date range
- Request an ID card
- Sign up for electronic communications and get your information faster and more securely

Signing up is easy

Visit **www.carefirst.com/myaccount,** click on *Register Now* and set up your User ID and Password. You'll just need information from your member ID card.

Additional tools

Depending on your specific health plan, you may have access to the following services through *My Account:*

- Find out the exact dollar amount you'll pay at a particular pharmacy
- View a side-by-side comparison of costs at local pharmacies
- Download claim forms
- Find in-network providers
- Track your reward progress
- Compare costs from different doctors, hospitals and facilities with our Treatment Cost Estimator

Mobile access

View the most-visited information in *My Account* on your smartphone or tablet.

Our mobile site is available from any browser-equipped mobile device. To try out the app, visit your favorite app store, search for "CareFirst" and install the CareFirst app on your device.

Enjoy access to:

- Find A Provider
- Search for nearby urgent care and ER facilities, based on your current location (as determined by your device's GPS).
- Searchable claims information
- Who's eligible and covered under your policy
- View your ID cards (App users can also print and email ID cards)
- Register for *My Account* and maintain your security and notification preferences.

For more information on our mobile site and app, visit **www.carefirst.com/mobileaccess.**

Medical Benefits Options

Effective for plan year July 1, 2015–June 30, 2016

The Benefits	CareFirst BlueCross BlueShield Preferred Provider Organization (PPO)	
	In-Network	Out-of-Network
DEDUCTIBLE (CONTRACT YEAR)	$250 Individual/$500 Family	$500 Individual/$1,000 Family
OUT OF POCKET MAXIMUM (CONTRACT YEAR)		
Medical	None	$2,000 Individual/$4,000 Family
Prescription Drug	$4,600 Individual/$9,200 Family	
PHYSICIAN SERVICES		
Surgeon	100% AB after deductible	Covered at 80% of AB after deductible
In-Hospital Medical	100% AB after deductible	80% AB after deductible
HOSPITAL		
Hospital Room/Semi-Private*	100% AB after deductible/365 days	80% AB after deductible/365 days
Outpatient Surgery	100% AB after deductible	80% AB after deductible
Emergency Care (within 72 hours)		
Facility	100% AB after $150 copay (waived if admitted)	100% AB after $150 copay (waived if admitted)
Facility/Practitioner	100% AB	100% AB
Provider's Office	100% AB after $30 copay	100% AB after $30 copay
MEDICAL SERVICES		
Diagnostic X-rays	100% AB, no deductible	80% AB in office after deductible
Radiation & Chemotherapy	100% AB physician 100% AB	80% AB after deductible
Laboratory tests	100% AB, no deductible	80% AB after deductible
Allergy testing	100% AB after $30 copay	80% AB after deductible
Allergy Treatment/Injections	100% AB after $30 copay	80% AB after deductible
Physical, Speech and Occupational Therapy	$30 office copay $55 outpatient facility copay Outpatient professional 100% AB 100 visit limit combined per benefit period	80% AB after deductible 100 visit limit combined per benefit period
PREVENTIVE CARE		
Well Baby & Child Care	100% AB (no deductible)	80% AB (no deductible)
Immunization	100% AB (no deductible)	80% AB (no deductible)
Annual Physical Exam	100% AB (no deductible)	80% AB after deductible
Annual Gynecological Exam	100% AB (no deductible)	80% AB after deductible
Eye Exams	No benefit for routine exam	No benefit for routine exam
Eye Glasses	No benefit	No benefit
OFFICE		
Medical Visits for Illness	100% AB after $30 copay per visit (no deductible)	80% AB after deductible

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

** Precertification required or penalties may apply.*

BlueChoice Opt-Out Plus	
In-Network	**Out-of-Network**
None	$300 Individual/$600 Family
None	$2,000 Individual/$4,000 Family
$4,600 Individual/$9,200 Family	
100% AB inpatient; $15 PCP/$25 Specialist copay in office	80% of AB after deductible
100% AB	80% of AB after deductible
$100 copay per admission	80% of AB after deductible
$50 copay	80% of AB after deductible
$150 copay Emergency Room (waived if admitted)	$150 copay Emergency Room (waived if admitted)
$25 copay Urgent Care Center	$25 copay Urgent Care Center
$15 PCP/$25 Specialist copay	$15 PCP/$25 Specialist copay
100% AB	80% of AB after deductible
100% AB	80% of AB after deductible
100% AB (LabCorp only)	80% of AB after deductible
$15 PCP/$25 Specialist copay	80% of AB after deductible
$15 PCP/$25 Specialist copay	80% of AB after deductible
$25 copay up to 30 visits per condition per contract year when approved by HMO/HMO physician (PT & OT combined)	80% of AB after deductible
100% AB	80% of AB
100% AB	80% of AB
100% AB	80% of AB
100% AB	80% of AB
$10 copay at BlueChoice designated vision center (one per plan year)	$10 copay at BlueChoice designated vision center (one per plan year)
Discounts available through Davis Vision	Discounts available through Davis Vision
$15 PCP/$25 Specialist copay	80% of AB after deductible

Medical Benefits Options

Effective for plan year July 1, 2015–June 30, 2016

The Benefits	CareFirst BlueCross BlueShield Preferred Provider Organization (PPO)	
	In-Network	Out-of-Network
SPECIAL SERVICES		
Hearing aid evaluation test (one every 36 months)	100% AB (no deductible)	80% AB after deductible
Basic Hearing aids (one every 36 months)	100% AB (no deductible)	80% AB after deductible
Home Health Care Visits	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)
Maternity Care	100% AB after deductible	80% AB after deductible
Ambulance (when medically necessary)	100% AB no deductible	100% AB no deductible
Chiropractic Services (limited to 20 visits per year)	100% AB after $30 copay	80% AB after deductible
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED		
Inpatient Care*	Inpatient Hospital: 100% AB after deductible Halfway House: 100% AB after deductible	Inpatient Hospital: 80% AB after deductible Halfway House: 80% AB after deductible
Outpatient Care	100% AB after $30 copay per visit (no deductible)	80% AB after deductible
PRESCRIPTION DRUG PROGRAM		
Prescription Drug**	$10 copay—Generic drugs $25 copay—Preferred Brand drugs $45 copay - Non-preferred drugs Maintenance drugs: Retail—3 copays Mail Order—2 copays	

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

** Precertification required or penalties may apply.*

BlueChoice Opt-Out Plus	
In-Network	**Out-of-Network**
$25 copay/visit (once every year)	80% of AB after deductible
Limited to one hearing aid per hearing impaired ear every 36 months	80% of AB after deductible
100% AB	80% of AB after deductible (limited to 40 visits/benefit period)
Hospitalization—$100 copay per admission Professional pre/post natal care—100% AB	80% of AB after deductible
100% AB	80% of AB after deductible
$25 copay/visit	80% of AB after deductible
$100 copay per admission	80% of AB after deductible
$15 copay	80% of AB after deductible
$5 copay—Generic drugs $15 copay—Preferred Brand drugs $35 copay - Non-preferred drugs Maintenance drugs: Retail—3 copays Mail Order—2 copays	

Your Medicare Supplemental Plan

Your protection against illness and high medical costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Harford County Government has selected the CareFirst BlueCross BlueShield Medicare Supplemental Plan for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare-covered services. That way, you can just concentrate on feeling better.

Using your benefit summary

This benefit summary will show you how to use the Medicare Supplemental Plan. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the Definitions Section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the Medicare Supplemental Plan is and how it works.
- What Medicare does and doesn't cover.
- When you'll need to file claims, and how to file them.
- How to get the most from your health care plans.
- What your Medicare Supplemental benefits are.

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at (800) 628-8549. You can call between 8:00 a.m. and 10:00 p.m., Monday through Friday and 8:00 a.m. and 1:00 p.m., Saturday. A customer service representative will be happy to help you.

What your plan is and how it works

What does the Medicare Supplemental Plan cover?

First, it covers your inpatient Medicare deductible and coinsurance, costs associated with emergency care, outpatient surgery and diagnostic services. Second, CareFirst BlueCross BlueShield will pay 80% of the difference between what Medicare pays and the Medicare approved amount (when you visit Medicare participating providers) or limiting charge (when you visit Medicare non-participating providers) for Major Medical services such as office visits and durable medical equipment.

How does the Medicare Supplemental Plan work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare-covered services. Your Medicare Supplemental Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare - covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as "accepting assignment."

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services. Please refer to questions 4 & 5 for examples.

How can I save money with my Medicare Supplemental Plan?

Your Medicare Supplemental Plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts,

regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your Medicare Supplemental Plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

Why is it better to use Medicare participating providers?

When you use Medicare participating providers for Medicare and Major Medical covered services, you save money. Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
Balance	$5.60
CareFirst pays 80% of $5.60 balance	$4.48
You pay remaining 20% coinsurance	$1.12

How much will I pay if I use Medicare non-participating providers?

Medicare non-participating providers can charge you the difference between the Medicare approved amount and the Medicare limiting balance. The difference is usually 15% more than the approved amount.

For example, a Medicare participating provider charges the approved amount for a service, say $28. A Medicare non-participating provider charges you up to the limiting charge, which would be about $32.20.

Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare limiting charge (15% greater than Medicare approved amount)	$32.20
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
Balance	$9.80
CareFirst pays 80% of $5.60	$4.48
You pay remaining balance up to Medicare limiting charge	$5.32

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

How can I find out if a doctor is participating with Medicare?

There are two ways you can check on a doctor's participation with Medicare:

- Check the Medicare MedPar Directory (you can receive your own copy by calling Medicare).
- Call the provider directly.

What Medicare does and doesn't cover

What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges.
- Care in a skilled nursing facility after a hospital stay.
- Home health care provided by a Medicare – participating home health agency.
- Hospice care for the terminally ill.

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services.
- Outpatient hospital services.
- Home health visits.
- Physical and speech therapy.
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment.

What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

What you'll need to file claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your Traditional Medicare Supplemental Plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

CareFirst Blue Cross Blue Shield
Mail Administrator
P.O. Box 14114
Lexington, KY 40512

What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (800) 342-7287. You can also call these numbers if you want to find out if your claim has been received.

Is there a deadline for filing claims?

Yes, we must receive your claims by December 31 following the year in which you receive medical care.

For example, if you received care in January of 2010, you should file your claim no later than December 31, 2011.

What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Getting the most from your health care plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

- Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.
- Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services.
- Always give your Medicare membership number and your CareFirst membership number when you receive care.
- If you need to file a claim, file right away so that you don't miss the filing deadline.

Your retail prescription drug plan

Your medical ID card is also your Rx card and should be given to the pharmacy each time you fill a prescription. You will pay a 20% copayment up front for your prescriptions. We encourage you to shop around for the best price to reduce your out-of-pocket expense. Pharmacy claims cannot be submitted on a Major Medical claim form for reimbursement.

Mail service prescription drug program sponsored by CVS

A mail service prescription drug program is a special added feature to your Medicare Supplemental Plan. For those who regularly take maintenance medications, this service provides a convenient and inexpensive way for you to order these medications and have them delivered to your home.

You can order up to a 90-day supply of medication for the required copayment of $10. You must send the $10 copayment with your prescription to CVS. The copayment will not be reimbursed through your medical benefits.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CVS toll-free patient services telephone number, Monday through Friday at (800) 241-3371.

Harford County Medicare Supplemental Plan

Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
FACILITY				
Inpatient Hospital Days 1–60 Days 61–90 Lifetime reserve	Part A initial deductible $1,260 $315 per day $630 per day	 $1,260 $315 per day $630 per day	No member payment No member payment No member payment No member payment	No member payment No member payment No member payment No member payment
Skilled Nursing Facility Days 1–20 Days 21–100	 None $157.50 per day	 None $157.50 per day	 No member payment No member payment	 No member payment No member payment
Home Health	None	None		
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost	No member payment	No member payment
PHYSICIAN SERVICES				
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit	No member payment	No member payment
Emergency	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Laboratory Services	100%	None	No member payments	N/A
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Office Visit	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Office Therapy				
Radiation/Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit	No member payment	No member payment
Physical Therapy	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge

The Medicare deductibles and coinsurance amounts shown are based on 2014 figures. Your benefits will automatically adjust to meet any amounts that change in 2015.

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/ Medicare limiting charge.

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
OTHER SERVICES				
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Prosthetic Appliances	20% of Medicare's approved amount deductible	100% up to allowed benefit	No member payment	No member payment
Whole Blood (In full – Part A, 3 pint deductible – Part B)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Hearing Benefits (once every 36 months)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Physical Exam		100% of allowed benefit	No member payment	No member payment
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
Prostate Cancer Screening	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.

Medicare does not place a limiting charge on durable medical equipment, therefore the CareFirst allowed benefit will prevail.

If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Supplemental Plan benefits may be provided.

Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.

Reimbursement under Major Medical is subject to an annual deductible of $200 per individual. After your deductible is met, payment is made at 80% of allowed benefit and you pay the coinsurance of 20%.

Words You Need to Know

Medicare Supplemental

Approved Amount

The amount that Medicare allows participating providers to be paid for Medicare – covered services. Payments are made according to the Medicare fee schedule (see page 30).

Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".

Coinsurance

Some services require that you pay a percentage of the costs for your medical care. For example, under Medicare Part B, you pay 20% and Medicare pays 80%.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days.

Your Traditional Medicare Supplemental Plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay. For example, under Medicare Part A, you must pay the first $1,100 of your hospital bill. And under Medicare Part B, you must pay the $200 deductible for services. Then Medicare begins to pay its share.

Limiting Charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare – covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you.

The limiting charge does not apply to any of the Traditional Medicare. Supplemental Plan benefits that Medicare does not cover.

Medicare Fee Schedule

In general, payments for services are made according to the standard Medicare – approved fee schedule.

Medicare Participating Providers

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare Non-Participating Providers

Other physicians and suppliers who do not agree to always accept the Medicare approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare – covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

PPO Plus Premier Dental

Plan Benefit Highlights for: Harford County Governmental Entities
Group No: 00430 - 00001, 00002 & 09999

Eligibility	Primary enrollee, spouse and eligible dependent children to end of month that dependent turns 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	$25 per person / $75 per family each plan year Yes			
Maximums D & P counts toward maximum?	$1,500 per person each plan year No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and posterior composite restorations	80 %	80 %
Endodontics (root canals)	80 %	80 %
Periodontics (gum treatment)	80 %	80 %
Oral Surgery	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Dependent children to age 20	50 %	50 %
Orthodontic Maximums	$ 1,000 Lifetime	$ 1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

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PPO Dental

Plan Benefit Highlights for: Harford County Governmental Entities
Group No: 00430 - 01001, 01002 & 01999

DELTA DENTAL PPO℠
BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to end of month dependent turns 26			
Deductibles	**Delta Dental PPO Dentist:** $25 per person / $75 per family each plan year **Non-Delta Dental PPO Dentist:** $75 per person / $150 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each plan year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	75 %
Basic Services Fillings and posterior composite restorations	80 %	60 %
Endodontics (root canals)	80 %	60 %
Periodontics (gum treatment)	80 %	60 %
Oral Surgery	80 %	60 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	35 %
Prosthodontics Bridges, dentures and implants	50 %	35 %
Orthodontic Benefits Dependent children to age 20	50 %	35 %
Orthodontic Maximums	$ 1,000 Lifetime	$ 1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 3/24/2015)

CareFirst Mobile Access

Keep us with you wherever you go!

With CareFirst's new app and mobile website, you can view the most-visited information in *My Account* on your smartphone or tablet.

Enjoy access to:

- Find a Provider
- Search for nearby urgent care and ER facilities, based on your current location (as determined by your device's GPS)
- Searchable claims information
- Who's eligible and covered under your policy
- View your ID cards (App users can also print and email ID cards)
- Register for *My Account* and maintain your security and notification preferences

Download our free app to your Apple® or Android® mobile device by searching for "CareFirst" in your favorite app store. Or, type **www.carefirst.com** into your mobile web browser, and you will be directed to our mobile site.

To view your personal information, register for *My Account* at **www.carefirst.com** from your computer or mobile device. If you haven't registered, you can still look for regional health care providers and nearby urgent care centers, or contact a CareFirst customer service rep. For more information, visit **www.carefirst.com/mobile**.

Download our free app to your Apple® or Android® mobile device by searching for "CareFirst" in your favorite app store.

Select Vision Program

Making vision care more affordable

Vision is one of our most valued assets. Everyone should take precautions to protect this priceless gift. Some vision problems, such as glaucoma, can only be detected through regular, professional vision exams. Without proper care, these problems can gradually grow worse.

Vision benefits: An affordable option

Vision care is one of the least expensive health care benefits you can purchase. It is also one of the first optional benefits chosen by employees when it is offered.

Select Vision helps you commit to routine eye exams and preventive care that help detect small problems before they become serious and costly. Select Vision provides benefits for:

- Comprehensive vision examinations
- Lenses and frames or contact lenses

Need more information? Please visit **www.carefirst.com**.

A name you can trust

CareFirst BlueCross BlueShield is one of the largest health insurers in Maryland. You will be pleased that you have chosen CareFirst BlueCross BlueShield to provide such an important and valuable benefit program.

Freedom of choice

With Select Vision you can choose any licensed vision care provider—in Maryland or out of state. You have complete freedom to choose your own ophthalmologists, optometrists, and opticians. You may choose to see your current provider, a provider convenient to work or home, or take the recommendations of others.

Easy to use

You simply show your CareFirst BlueCross BlueShield membership card to participating providers at the time of service. The participating provider will bill us and we pay them directly for their services. You don't have any paperwork or claims to file.

If you choose a non-participating provider for your care, you must pay the provider. We will reimburse you up to the limits of your vision plan.

Select Vision

Making vision care more affordable

Participating providers save you money

Participating providers agree to accept our reimbursement as payment in full for routine eye examinations.

You can identify participating providers by the distinctive CareFirst BlueCross BlueShield Participating Provider plaque in their offices. If you don't see the plaque, you can ask the provider if he or she participates with CareFirst BlueCross BlueShield before you receive care. You may also call CareFirst BlueCross BlueShield member services to find out if a provider participates.

Non-participating providers

You can also receive vision exams, frames and lenses, or contact lenses from non-participating providers. You must pay these providers for these services and submit any bills or receipts to CareFirst BlueCross BlueShield. We will directly reimburse you up to the allowed benefit or scheduled amount. You are responsible for any difference between our allowed benefit and the billed charges.

What is not covered

- Sunglasses (lenses darker than tint 2), even if prescribed.
- Replacement, within the same benefit period, of lost or damaged frames or lenses (including contacts) for which benefits were provided.
- Exams or materials furnished after the member's coverage is terminated (unless lenses and frames or contact lenses are ordered prior to the termination date and received within 30 days after the date of the order).
- Separate exam for contact lens fitting.

EYE EXAMINATIONS	100% of the Allowed Benefit		
GLASSES	**LENSES** *(per pair)*	**FRAMES** *(per pair)*	**MAXIMUM ALLOWANCE**
Single Vision	$41.50	$29.50	$71.00
Bifocal	$67.00	$29.50	$96.50
Trifocal	$89.50	$29.50	$119.00
Double Bifocal	$100.50	$29.50	$130.00
Cataract (Aphakic)	$156.50	$29.50	$186.00
CONTACT LENSES *(per pair)**			
Single Vision (not medically required)	$71.00		
Bifocal (not medically required)	$96.50		
Medically Required (following cataract surgery or when vision acuity is correctable to at least 20/70 in the better eye only by use of contact lenses)	$221.00		

** Fashion contact lenses, which are not corrective, are not included in the schedule of benefits.*

Not all services are covered by your benefits contract.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

www.carefirst.com

Health benefits administered by:

CareFirst

CONNECT WITH US:

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